STATE MEDICAL EDUCATION BOARD OF GEORGIA

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September 9, 2010

Dear Applicant:

Enclosed are application materials for the State Medical Education Board *Physicians for Rural Areas Assistance Program*. The attached Applicant Information Bulletin gives a description of the program for the fiscal year of July 1, 2010 through June 30, 2011.

The purpose of this program is to grant service cancelable loans of up to $25,000 to physicians to repay outstanding medical education debt in return for medical practice in underserved rural areas in Georgia. Contracts are awarded for one year and are renewable for a maximum of four years.

The Board will consider data gathered by the Georgia Board for Physician Workforce in determining the relative need for physicians in specific rural areas. The Board will then establish a ranking of locations in the applicant pool. Selection priority will be given to those applicants who are physicians specializing in and actively practicing specialties as approved by the Board at their July meeting.

Complete the attached Provider Application and return it with appropriate attachments by November 1, 2010. Your application will not be considered complete until all application materials have been received. Applications will be presented to the State Medical Education Board for approval at the December Board meeting.

Please contact our office at 404-206-5420 or smeb@dch.ga.gov if you have questions.

Sincerely,

Cherri Tucker
Executive Director

Enclosures

State Medical Education Board of Georgia

Physicians for Rural Areas Assistance Program

Applicant Information Bulletin

This document describes the Physicians for Rural Areas Assistance Program. Program participants will be bound by contract to adhere to the provisions outlined in this document.

Keep this Bulletin for future reference.

STATE MEDICAL EDUCATION BOARD OF GEORGIA
PHYSICIANS FOR RURAL AREAS ASSISTANCE PROGRAM

PURPOSE OF THE PROGRAM

The purpose of the Physicians for Rural Areas Assistance Program is to increase access to high quality medical care for medically underserved rural communities in Georgia.

PROGRAM REQUIREMENTS AND CONTRACTUAL OBLIGATIONS

The Physicians for Rural Areas Assistance Program pays medical education student loan debt for physicians who agree to practice medicine full time in a rural community in Georgia. The program provides up to $25,000 a year in student loan repayment in return for a 12-month commitment to practice in a rural community. Recipients may receive a maximum of four loans and a maximum total student loan repayment of $100,000.

The Physicians for Rural Areas Assistance Contract requires a commitment to practice medicine a minimum of 40 clinical hours per week in a Georgia County with a population of 35,000 or fewer people according to the 2000 Census Count of the United States Bureau of the Census. The practice time requirement can be split between two or more counties, provided that none of the practice location counties exceeds the 35,000 population limit.

The physician may own the practice or the physician may be employed by a hospital, group medical practice, community health center, or other health care organization. There is no requirement that the practice be a not for profit organization. However, the physician must participate in the Medicaid program and must agree to accept new patients insured by Medicaid.

Funding is based upon the amount of funds appropriated to the State Medical Education Board by the Georgia General Assembly. Funding for 2010-2011 contracts will be up to $25,000 each. Funds are disbursed in a lump sum directly to the recipient's lenders.

The Board will consider data gathered by the Georgia Board for Physician Workforce in determining the relative need for physicians in specific rural areas. The Board will then establish a ranking of locations in the applicant pool. Selection priority will be given to those applicants who are physicians specializing in and actively practicing specialties as approved by the Board at their July meeting.

All recipients are required to sign a contract with the State Medical Education Board agreeing to the terms and conditions upon which awards are granted. This contract establishes the amount of the award, the location of service repayment, the contract date (also the beginning and end date of service), as well as the terms and conditions of program participation, obligated service and the conditions of default and cash repayment.

ELIGIBLE STUDENT LOANS

Student loans incurred for tuition, fees, and other expenses associated with completion of your medical degree are eligible for payment under the Physicians for Rural Areas Assistance Program.

Student loan debt incurred to complete other academic degrees is not eligible for payment under the Physicians for Rural Areas Assistance Program.

APPLICATION REQUIREMENTS

Eligible Applicants must:

- Be a citizen or national of the United States;
- Have satisfied all requirements for unrestricted medical licensure by the Georgia Composite Medical Board at the time the loan is made;
- Be a graduate of an accredited graduate medical education program located in the United States which has received accreditation or provisional accreditation by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;
- Hold a Medicaid Provider Number in Georgia and actively treat Medicaid patients;
- Be in good standing with regard to meeting the contractual requirements of existing student loans;
- Establish and maintain residence in the community in which you practice;
- Submit an application to participate in the Physicians for Rural Areas Assistance Program no later than November 1st. (Submitting an application does not guarantee selection);
- Disclose all outstanding medical education loan debt;
- Submit executed copy of employment contract. If self employed in private practice, must submit a copy of any hospital agreements/contracts.
- Contractually agree to practice full-time (minimum of 40 clinical hours per week); and
- Have completely satisfied any other obligation for health professional service owed under any agreement with the Federal Government, State Government, or other entity prior to the beginning of service under this program.

NOTE: Applicants who are recipients of the State Medical Education Board Scholarship Program must extend their period of service obligation by the period of service obligation required by the Physicians for Rural Areas Assistance Program.

INITIAL APPLICATION PROCESS

Completed applications must be received no later than November 1st for consideration during the fiscal year.

Application forms are available from the State Medical Education Board office at 1718 Peachtree Street, NW, Suite 683, Atlanta, Georgia 30309, telephone (404) 206-5420. A downloadable version of the application form is available at www.smeb.georgia.gov.

All information requested in the Application must be complete prior to Board consideration.

Further information is available by contacting the Board offices. The Board may request that the candidate make a personal appearance before the Board, although this is not typically the case.

A Notice of Award letter and Acceptance of Award form will be mailed to those applicants approved by the Board. Upon receipt of the Acceptance of the Award form, the Board will issue a Physicians for Rural Areas Assistance Program contract. Payment of the Award is made once the contract is fully executed.

RENEWAL APPLICATION PROCESS

Contracts may be renewed for additional one-year terms for a maximum of four years or up to $100,000. Each recipient is required to complete and submit an annual status report to the Board. Renewal applications are available from the State Medical Education Board Offices and are due no later than November 1st of each year.

A Notice of Award and an Acceptance of Award form will be mailed to those applicants approved by the Board. Upon receipt of Acceptance of the Award form, the Board will issue a Physicians for Rural Areas Assistance Program contract. Payment of the Award is made once the contract is fully executed.

CONTRACT DEFAULT

The contract includes a penalty of double the principal award amount received for:

1. Failure to begin or complete the full twelve-month service commitment in the location named in the contract,
2. Failure to meet the 40 clinical hours per week full-time practice commitment, or
3. Failure to provide Board staff with access records and other information necessary to document compliance with contract terms.

The cost of attorney fees and other expenses associated with collection are assessed in addition to the double default penalty.

PRACTICE LOCATION ASSISTANCE

In cooperation with other interested organizations and rural Georgia communities, the State Medical Education Board sponsors an annual Medical Fair. This function is designed to enable physicians to meet representatives from 25-30 qualifying rural Georgia communities to discuss practice opportunities in our State.

Interested parties can also contact the Georgia Board for Physician Workforce. The Georgia Board for Physician Workforce maintains information pertaining to practice opportunities statewide. Many of these opportunities are rural locations eligible for loan repayment.

FURTHER INFORMATION AND ASSISTANCE

Please contact the State Medical Education Board of Georgia if you have any questions or need additional information.

The State Medical Education Board of Georgia
1718 Peachtree Street, NW, Suite 683
Atlanta, Georgia 30309-2496
404-206-5420-Office
404-206-5428-Fax
smeb@dch.ga.gov

STATE MEDICAL EDUCATION BOARD

Application

PHYSICIANS FOR RURAL AREAS ASSISTANCE PROGRAM

SECTION I - PERSONAL DATA

Please type or print with black ink.

Applicant's Full Legal Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____ Home Phone: _____

Social Security #: _____ Birth Date: _____

Birth Place: _____ Email Address: _____

SECTION II - SPECIALTY

_____ M. D. _____ D. O.

_____ Family Practice ___ with OB

_____ General Pediatrics

_____ General Surgery

_____ General Internal Medicine

_____ Obstetrics/Gynecology

_____ Other, Name Specialty:

_____

SECTION III – MEDICAL EDUCATION

Medical School: _____ Graduation Date: _____

City: _____ State: _____

Residency Hospital: _____ Graduation Date: _____

City: _____ State: _____

Board Certified: ____ Board Eligible: ____ GA Medical License Number: _____

SECTION IV – PRACTICE SITE

Applicant agrees to provide full-time primary care services in _____ for one year at:
Medical Specialty

Practice Site Name: _____

Address: _____

City: _____ County: _____ Zip Code: _____

Telephone: _____ Fax: _____

Type of practice: ___ Hospital Based ___ Group ___ Solo ___ Private ___ CHC

Federal Employer Identification Number for practice: _____
OR Attach 501 C-3 (IRS non-profit documentation), if applicable.

Medicaid Provider Number: _____ Beginning Date of Practice: _____

Number of clinical hours per week at this practice location: _____

Include a copy of the contract between yourself and your practice/employer.

SECTION V – MEDICAL EDUCATIONAL DEBT

Estimate of total outstanding MEDICAL educational debt from all loan holders: $_____

Request submission of the attached *Lender Disclosure Form* from each loan holder.
Attach a current loan statement for each loan listed. Loan statements must contain Applicant's name, account number, the principle and payoff balance.

1. Loan Holder: _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $_____

2. Loan Holder: _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $_____

3. Loan Holder: _____

   Loan Holder Address: _____

   City: _____ State: _____ Zip Code: _____

   Account Number: _____ Loan Balance: $_____

SECTION V – MEDICAL EDUCATIONAL DEBT (Continued)

4. Loan Holder: _____

Loan Holder Address: _____

City: _____ State: _____ Zip Code: _____

Account Number: _____ Loan Balance: $_____

5. Loan Holder: _____

Loan Holder Address: _____

City: _____ State: _____ Zip Code: _____

Account Number: _____ Loan Balance: $_____

SECTION VI - CERTIFICATION

I certify that the information given in this application is accurate and complete to the best of my knowledge and belief. I hereby consent fully to verification of any and all information included in this application. I understand that any willfully false representation of information is sufficient cause for rejection of this application. I have fully disclosed all outstanding load debt and am not currently in default of any service or loan obligation.

_____ _____

Applicant's Signature (Full Legal Name) Date

Official Notary:

I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgments, _____ (applicant's name), to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at the City of _____, County of _____ and

State of _____, this _____ day of _____, 20____.

_____

Notary Public (Full Legal Signature)

Affix Seal My commission expires: _____

Mail your completed application to:

State Medical Education Board of Georgia
Physicians for Rural Areas Assistance Program
1718 Peachtree Street, NW, Suite 683
Atlanta, Georgia 30309-2496

Direct questions to 404-206-5420 or
smeb@dch.ga.gov

STATE MEDICAL EDUCATION BOARD OF GEORGIA
AUTHORIZATION and RELEASE FORM
for the Physicians for Rural Areas Assistance Program

FULL LEGAL NAME OF APPLICANT: _____

TO WHOM IT MAY CONCERN:

I, _____, have filed an application with the State Medical Education
Applicant's Full Legal Name
Board of Georgia's Physicians for Rural Areas Assistance grant to repay the cost of my tuition and other expenses while obtaining my medical education and training. I recognize that it is the responsibility of the members of said Board to determine that only those qualified persons of high character and recognized ability, who have entered into a contract with an eligible practice entity, submitted all required application forms and documentation and closed all medical education debts and obligations, are eligible for loan repayment. To this end, and for the entire contract period, I hereby authorize and request any college or school official, lending institution or organization and any other person or official of any firm, association or corporation, including, but not limited to, those persons whose names I have given as personal references on my application, to answer any inquires, questions, interrogatories, or furnish any information whatsoever concerning the undersigned on forms or requests which may by submitted to them by the State Medical Education Board or its authorized representative, and to appear before said Board, or its authorized representative, and to give full and complete testimony concerning the undersigned, including any information furnished by the undersigned. I hereby relinquish any and all rights to said reports, evaluations, consultations, letters of recommendation or any other information or material incident in any way to authorized reviews by State Medical Education Board, or its authorized representative, and fully understand that I shall not be entitled to have disclosed to me the contents of any of the foregoing.

I hereby release and exonerate all such persons authorized by the State Medical Education Board, who shall comply in good faith with this authorization and request from any and all liability of every nature and kind whatsoever growing out of or in any way pertaining to the furnishing of such information or inspection of any document, record and other information or any investigation by said State Medical Education Board.

Further, the undersigned hereby waives absolutely any right which he/she may have under the laws of Georgia governing confidential or privileged communications, as codified in Sections 38-418, 38-419.1 of the Georgia Code Annotated, as now or hereafter amended.

IN WITNESS WHEREOF, I have set my hand and seal this _____day of _____, 20_____.

_____
Applicant's Full Legal Signature

STATE OF _____ **COUNTY OF** _____

OFFICIAL NOTARY:

I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgments, _____,
Applicant's Full Legal Name
to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at City of _____, County of _____

and State of _____, this _____day of _____, 20_____.

_____
(Place Seal Imprint Here) **Legal Signature, Notary Public**

My Commission Expires: _____

Revised: August 2009

Physicians for Rural Areas Assistance Program

Outstanding Medical Education Loan Debt Information

---------LENDER DISCLOSURE--------

Applicant: This form must be sent to each lending institution or agency for which you are seeking loan repayment. The lending institution should forward the completed form to our office.
Lender: If the named individual's application is approved, the information requested below will be used to arrange third party pre-payment of a portion or all of the applicant's debt.

Applicant's Name as it Appears on Loan: _____

Original Lending Institution, Federal or State Program, Please Provide:

Full Name of Institution or Program | Contact Person | Telephone Number

Street Address | City | State | Zip

_____ $_____ _____
Loan ID Number | Original Loan Amount | Date of Original Loan

_____ $_____ _____
Grace Period/Forbearance Dates | Current Balance | Date of Balance

_____% _____
Interest Rate | Simple or Compound

If interest rate is variable, explain terms: _____

Purpose of loan as indicated on <u>original</u> loan application: _____

Certification by Applicant Borrower:
I hereby authorize the government or financial Institution named above to release this information to the State Medical Education Board of Georgia for the purpose of repayment of outstanding medical education debt through the Physicians for Rural Areas Assistance Program.
I also certify the accuracy of the enclosed information and apply to enter into an agreement with the STATE MEDICAL EDUCATION BOARD OF GEORGIA - PHYSICIANS FOR RURAL AREAS ASSISTANCE PROGRAM of all or the appropriate portion of the education loan listed above, incurred solely for the cost of medical education, including reasonable living expense at a school of medicine.

Full Legal Signature: _____ **Date**: _____

Certification by Authorized Agency of Lending Institution:
The undersigned states that, to the best of his or her knowledge, the loan identified above is a bona fide, legally enforceable, commercial, state or government educational loan, made for the purpose of meeting the borrower's costs of attaining the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.).

_____ _____
Print/Type Name of Authorized Agent | Title

Official Signature: _____

Lender Organization's Federal Employer Identification Number:_____

Return to: State Medical Education Board of Georgia, 1718 Peachtree Street, NW, Suite 683, Atlanta, GA 30309-2496

Make additional copies as needed.

Physician Applicant Summary Data Sheet

Physician's Full Legal Name: _____

Social Security Number: _____ Physician License Number: _____

Medical Specialty:_____ Subspecialty:_____

Date Available for Practice: _____ Practice Start Date: _____

Estimated total amount of outstanding medical education loan debt: $_____

Practice Name: _____ County Name: _____

Street Address: _____ Telephone: ( ) _____

_____ Zip Code: _____

Ownership of Practice: _____

Type of Practice: _____ *Not-for-profit*
_____ *Public*
_____ *Private*

Medicaid provider number: _____

Referral Hospital: _____

Hospital Address: _____

City/ST/ZIP: _____

County Name: _____

Ownership of Hospital: _____

Type of Hospital: _____ *Not-for-profit* _____ *For-profit*

Attachment Checklist (check all application enclosures):

_____ Copy of employment contract _____ Lender Disclosure Form/s